DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Public Health

WISCONSIN WELL WOMAN PROGRAM (WWWP) ENROLLMENT FORM
DPH 4818 (Rev. 11/00)

Women interested in determining their eligibility for enrolling in the WWWP need to contact:

WWWP Local Coordinating Agencies

Form Begins on Next Page

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STATE OF WISCONSIN
s. 255.075, Wis Stats.

WISCONSIN WELL WOMAN PROGRAM (WWWP) ENROLLMENT

Read instructions on reverse prior to completing this form. Print clearly. Client information in this document is confidential under Wis. Stats 146.82

PERSONAL INFORMATION – Completed by Client

1. Last Name _____ 2. First Name _____ 3. Middle Name _____

4. Maiden Name _____ 5. Date of Birth (mm/dd/yyyy) _____ 6a. Social Security No. (Optional) _____ - _____ - _____

6b. Client Identification No. (Assigned by Local Coordinating Agency) _____ - _____ - _____

7. Race ☐ Aleutian ☐ American Indian ☐ Asian ☐ Black ☐ Eskimo ☐ Hmong ☐ Other ☐ Pacific Islander ☐ Unknown ☐ White

8. Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

9. Street Address _____ 10. City _____ 11. State _____ 12. Zip _____

13. County _____ 14. Day Telephone No. ( ) _____ 15. Night Telephone No. ( ) _____

16. Mailing Address _____ 17. City _____ 18. State _____ 19. Zip _____

20. Name of contact person, not living with you _____ 21. Relationship _____

22. Address _____ 23. City _____ 24. State _____ 25. Zip _____

26. Contact Person's DayTelephone No. ( ) _____ Night Telephone No. ( ) _____

ENROLLMENT INFORMATION – Completed by Enrollment Site

27. Enrollment Site Name _____ 28. Site City _____

29. Site County / Tribe _____ 30. Enrollment Date (mm/dd/yyyy) _____

31. Enrollment Site Number (if known) _____

INSURANCE INFORMATION – Completed by Client

32. Do you have any health insurance? ☐ Yes ☐ No 33. Do you have Medicare Part B? ☐ Yes ☐ No

HEALTH CARE PROVIDER INFORMATION – Completed by Client

34. Do you have a primary health care provider? ☐ Yes ☐ No 35. If Yes, Name of Provider _____

36. Street Address _____ 37. City _____ 38. State _____ 39. Zip _____

40. Do you have a primary care clinic? ☐ Yes ☐ No 41. If Yes, Name of Clinic _____

42. Street Address _____ 43. City _____ 44. State _____ 45. Zip _____

46. How did you hear about this program? ☐ WWWP Coordinator ☐ Relative / Friend ☐ Radio / TV ☐ Newspaper ☐ Brochure / Poster
☐ Clinic / Health Care Provider ☐ Other _____

47. CLIENT PARTICIPATION AGREEMENT

I understand and agree to the following; the Wisconsin Well Woman Program (WWWP) will use the personally identifiable information only for program enrollmen and case management. I give WWWP permission to release my medical information to the Local Coordinating Agency (LCA), other service providers, referra agencies and the State of Wisconsin. I understand that WWWP pays for preventive screening services, but does not pay for medical treatment services. I hav seen the current program eligibility criteria and, to the best of my knowledge, my annual income does not exceed them. All of the information I have given is tru and correct. I will inform the WWWP LCA if I move or if I no longer wish to participate. I understand the enrollment is valid for one (1) year from the date signed.

48. **SIGNATURE – Applicant** 49. **Date Signed**

50. **SIGNATURE – Witness** 51. **Date Signed**

Office Use Only

☐ New Enrollment ☐ Meets Eligibility Requirements ☐ Age_____ ☐ Income $_____ ☐ Household size____ ☐ Uninsured ☐ Underinsured

☐ Re-Enrollment ☐ Meets Eligibility Requirements ☐ Age_____ ☐ Income $_____ ☐ Household size____ ☐ Uninsured ☐ Underinsured

☐ Inactive ☐ Out or Area ☐ Deceased Date_____(mm/dd/yyyy)

☐ Refer for CBE and / or Mammogram Provider Name _____

☐ Refer for Pelvic and PAP Provider Name _____

☐ Refer for other Well Woman Screening Provider Name _____

Name of Interviewer _____

Return completed,white copy only, of form to: WWWP – Fiscal Agent, P. O. Box 6645, Madison, WI 53716-0645

White (Top) Copy– Fiscal Agent Yellow (2nd) Copy – Provider Pink (3rd) Copy – Local Coordinating Agency Blue (4th) Copy – Client

DPH 4818 (Rev. 11/00)

WISCONSIN WELL WOMAN PROGRAM (WWWP) ENROLLMENT INSTRUCTIONS

Completion of this form is required to determine your eligibility for services with WWWP. The Department of Health and Family Services has the authority to collect personally identifiable information necessary to determine eligibility for services for the WWWP. The personally identifiable information collected on this form will ONLY be used to determine eligibility for services and case management. Provision of the Social Security Number is optional.

PERSONAL INFORMATION

1. Print your last name.
2. Print your first name.
3. Print your full middle name.
4. Print your maiden name, if applicable.
5. Indicate date of birth. Use numbers for month, day and year, i.e. 01/15/1935.
6. Indicate your Social Security Number.

   6a. Your Social Security Number is optional and will be used to determine your eligibility for services and to identify your status with other health care programs.

   6b. If Client Identification Number is used instead of the Social Security Number, the Local Coordinating Agency should assign this number.
7. Indicate your race by checking the appropriate box. This information will be used for statistical purposes only.
8. Indicate your ethnicity by checking the appropriate box. This information will be used for statistical purposes only.
9. Indicate number and street address of your residence; include apartment number if applicable.
10. Indicate your city of residence.
11. Indicate your state of residence.
12. Indicate your residential zip code.
13. Indicate your county of residence.
14. Indicate your daytime telephone number, with area code. If there is no phone, indicate "none".
15. Indicate your night / evening telephone number, with area code. If there is no phone, indicate "none".
16. Indicate your mailing address, if different from your residential street address.
17. Indicate the city of your mailing address, if different from your residential address.
18. Indicate the state of your mailing address, if different from your residential address.
19. Indicate the zip code of your mailing address, if different from your residential address.
20. Indicate the name of a contact person, not living with you. This person should have a telephone.
21. Indicate the relationship of the contact person to you, i.e. husband, mother, son, neighbor, etc.
22. Indicate the contact person's address.
23. Indicate the city for the contact person's address.
24. Indicate the state for the contact person's address.
25. Indicate the zip code for the contact person's address.
26. Indicate the contact person's day or evening telephone number, with area code. If there is no phone, indicate "none".

ENROLLMENT INFORMATION

27. Indicate the client's enrollment site name. (example: Wisconsin County Medical Center)
28. Indicate the city of the enrollment site.
29. Indicate the county or tribe of the enrollment site.
30. Indicate the enrollment date. Use numbers for month, day and year, i.e 01/15/2001.
31. Indicate the enrollment site number (if known).

INSURANCE INFORMATION

32. Check "Yes" if you currently have private, group or other Health Insurance coverage as well as any other type of coverage. Check "No" if you do not.
33. Check "Yes" if you receive Medicare Part B. Check "No" if you do not.

HEALTH CARE PROVIDER INFORMATION

34. Check "Yes" if you have a primary health care provider (physician). Check "No" if you do not.
35. Indicate the name of your primary health care provider.
36. Indicate the street address for your primary health care provider.
37. Indicate the city where your primary health care provider is located.
38. Indicate the state where your primary health care provider is located.
39. Indicate the zip code for your primary health care provider.
40. Check "Yes" if you have a primary care clinic. Check "No" if you do not.
41. Indicate the name of your primary care clinic.
42. Indicate the street address of your primary care clinic.
43. Indicate the city where your primary care clinic is located.
44. Indicate the state where your primary care clinic is located.
45. Indicate the zip code where your primary care code is located.
46. Please indicate how you heard about the Wisconsin Well Woman Program by checking the appropriate box.

CLIENT PARTICIPATION AGREEMENT

47. Read the agreement carefully. If you have any questions regarding completion of this form, contact your Local Coordinating Agency.
48. Sign the agreement using your legal signature.
49. Indicate the date on which you sign this form.
50. The witness signature will verify that the client signed this form.
51. The witness will indicate the date that he / she signed this form.

Return completed form, White (Top) Copy Only to:

WWWP
P. O. BOX 6645
MADISON, WI 53716-0645